



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SENDERO IMAGING & TREATMENT CENTER
7220 LOUIS PASTEUR DRIVE SUITE 115
SAN ANTONIO TX 78229

Respondent Name

CITY PUBLIC SERVICE BOARD OF SAN ANTONIO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-12-0844-01

MFDR Date Received

November 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Under-paid-Appealed. Have not received a response."

Amount in Dispute: \$246.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Sendero Imaging did not indicate they were billing as an ambulatory center by using the modifier SG. City Public Service received a corrected 'clean' bill on April 26, 2011, which was outside the 95 day window to submit a corrected bill." "Therefore, City Public Board of San Antonio's reimbursement was appropriate."

Response Submitted by: City Public Service Board Of San Antonio, P.O. Box 1771, San Antonio, TX 78296

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2011	ASC Services for code 64483-SG-RT	\$246.55	\$246.55

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 Texas Administrative Code §133.250, effective May 2, 2006, sets out the reconsideration of medical bills process.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 3, 2011

- 76-Billing is greater than surgical service fee.
- W1-Workers compensation state fee schedule adjustment.

Explanation of benefits dated May 9, 2011

- 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Was the disputed bill timely filed?
2. Is the SG modifier required for ASC billing?
3. Is the requestor entitled to reimbursement for ASC services for CPT code 64483-SG-RT?

Findings

1. 28 Texas Administrative Code §133.250(d)(1) states "The request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill."

The respondent states in the position summary that "City Public Service received a corrected 'clean' bill on April 26, 2011, which was outside the 95 day window to submit a corrected bill."

On the original bill the requestor billed CPT code 64483-WP-RT for \$1280.00.

The requestor submitted a corrected claim for CPT code 64483-SG-RT for \$1280.00.

The Division finds that 28 Texas Administrative Code §133.250(d)(1) allows healthcare providers upon reconsideration to make corrections relating to modifiers. Therefore, the respondent's assertion regarding timely filing is not supported.

2. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

The respondent states in the position summary that "Sendero Imaging did not indicate they were billing as an ambulatory center by using the modifier SG. City Public Service received a corrected 'clean' bill on April 26, 2011, which was outside the 95 day window to submit a corrected bill."

Per Medicare policy "Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare ASC services. ASC providers will no longer be required to bill the SG modifier on Medicare ASC facility claims."

Therefore, the SG modifier is not required for ASC billing.

3. 28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

CPT code 64483 is defined as "Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level."

The MAR for CPT code 64483 is \$656.28 (\$279.27 X 235%). The respondent paid \$201.74. The difference between the MAR and amount paid is \$454.44. The requestor is seeking additional reimbursement of 246.55; this amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is \$246.55.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$246.55 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

7/23/2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.